Commonwealth of Massachusetts
Group Insurance Commission

Taking Steps to Improve Health Care Quality and Cost

Fiscal Year 2008 Annual Report

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

THE GROUP INSURANCE COMMISSION

The mission of the Group Insurance Commission is to provide high value health insurance and other benefits to state employees and retirees (including their survivors and dependents) - as well as providing these benefits to redevelopment, housing, and certain other authorities. The GIC also provides health-only benefits to participating municipalities' employees, retirees, and their survivors and dependents. The agency works with vendors selected through competitive bidding to offer cost-effective services through careful plan design and rigorous ongoing management. The agency's performance goals are providing affordable, high quality benefits, and as the largest employer purchaser of health insurance in the Commonwealth, using that position to help drive improvements in the entire health care delivery system.

The GIC Offers the Following Benefit Programs:

- A diverse array of health insurance options
- Term life insurance
- Long Term Disability (LTD) insurance
- Dental/Vision coverage for managers, Legislators, Legislative staff and certain Executive Office employees
- Dental coverage for retirees
- Discount vision plan for retirees
- Health Care Spending Account (HCSA)
- Dependent Care Assistance Program (DCAP)

COMMONWEALTH OF MASSACHUSETTS
GROUP INSURANCE COMMISSION
Fiscal Year 2008 Annual Report
Editor: Cynthia E. McGrath

Design and Printing: Red Sun Press
Printed on Recycled Paper
Printed January 2009

Dear Friends:

The more things change, the more they stay the same – in other words, the problem that will not go away continued to rear its unattractive head in FY08 – unsustainable health care cost increases. And, with a looming economic crisis, getting our arms around this cost monster requires action – immediately!

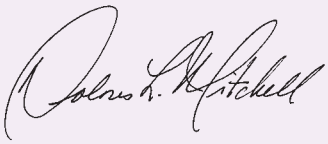
The GIC has been taking steps to rein in health care costs, while addressing gaps in the quality of care, since it began the Clinical Performance Improvement Initiative in 2003. This program identifies differences in care and rewards employees, through modest co-pay incentives, for using better performing doctors, and in some plans, hospitals. Throughout Fiscal Year 2008, this program continued to evolve and improve, garnering attention throughout the industry. As described in this Fiscal Year 2008 Annual Report, other employer purchasers and insurers are beginning to adopt aspects of this health care provider tiering initiative.

This is not to say the program has been without opponents. Most notably, the organized physician community has been less than enthusiastic about having individual physician performance evaluated. But like all transparency initiatives, we believe that this reporting will help physicians to improve their quality of care and be judicious in their use of costly resources. We continue to work with physicians and others in the health care industry to help advance and refine the program, and exciting strides have been made as a result of these efforts.

In addition to improving health care quality and cost for Commonwealth employees and retirees, the GIC worked to help municipalities lower their own health care costs. Much progress has been made in implementing the Municipal Partnership Act that allows municipalities to join the GIC's health insurance plans. These efforts are outlined in this report.

We hope that, as you read this annual report, you will agree that we are making great strides in improving health care quality and controlling costs for all Massachusetts residents.

Very truly yours,



Dolores L. Mitchell
Executive Director

Improving Health Care Quality While Containing Costs

Challenges

Rising health care costs and gaps in health care quality continue to pose formidable challenges:

- Health care cost increases have far outpaced increases in workers' earnings and overall inflation. According to the Kaiser Family Foundation, nationally, since 2001 family coverage health premiums have increased 78%, but
  - Wages have increased 19%
  - Inflation has increased 17%.
- Health care costs, including the GIC, now comprise 45% of the state's budget.
- The state is facing a sizable budget gap in FY09 and a challenging FY10.
- Numerous studies, including those conducted by the Institute of Medicine and the RAND Corporation, have shown wide disparities in quality of care.

The GIC Solution

The GIC has taken a different approach from other employers, who have cut benefits and reduced coverage, eliminated choice, implemented high-deductible plans, and/or eliminated retiree benefits. Instead, our approach has been to:

- Look at the health care system itself
- Urge providers (doctors and hospitals) to be part of the solution

The GIC's Clinical Performance Improvement Initiative, begun in the fall of 2003, seeks to:

- Maintain a comprehensive level of benefits
- Improve health care quality and safety
- Control cost increases for members and for the Commonwealth
- Maintain participants' choice of providers
- Educate members about differences in provider value and quality
- Encourage members to become informed health care consumers

Under the CPI Initiative, the GIC requires our health plans to provide de-identified claims for their entire book of business to our consultants to be aggregated and analyzed for each provider's efficiency and quality relative to his or her peers. After this process, the results of this analysis are given to the health plans, which then use the information to develop benefit designs in which members are given modest co-pay incentives to use better performing doctors and, in some plans, hospitals. In FY08, 150 million de-identified health claims representing 2.3 million lives and seven million complete episodes of care were analyzed, making this one of the largest multi-payer analytic databases of its kind being used in this manner.

Health plan benefits have evolved with the program in keeping with our goals. Members pay a lower co-pay to visit higher quality and cost-efficient providers:

Step 1: Tiered hospital networks implemented in Fiscal Year 2004

Step 2: Tiered physician networks introduced in Fiscal Year 2007

Step 3: Tiered physician networks evolved to a three-tier structure for Fiscal Year 2009. Physicians for whom there is not enough data and physicians who are in specialties that are not tiered by the plan are assigned the Tier 2 co-pay.

How Are Physician Tiers Determined?

Based on a thorough analysis of physician claims, GIC health plans assign physicians to tiers according to how they score on nationally-recognized measures of quality and cost efficiency. The Physician Advisory Committee, comprised of the medical directors from each of the GIC's health plans and private practice physicians, collaborate to improve this program and process. Every year improvements are made in linking individual providers to their claims across all health plans, which has made each iteration of the CPI Initiative more sophisticated, accurate, and useful.

Aspects of the GIC's program are beginning to be adopted by other purchasers and insurance companies: Aetna, Cigna and United Health Care plans offer health plans that tier physician office visit co-pays. CalPers, the benefits administrator of California's active and retired state and local government employees, has introduced "narrow network" plans, similar to some of the GIC's selective network options. Blue Cross Blue Shield of Massachusetts also now offers plans with tiered co-pays for network hospitals and physician group practices.

The CPI Initiative has not been without opposition, most notably from the Massachusetts Medical Society (MMS), which filed a lawsuit in the spring of 2008 against the GIC and two of our health plans (Tufts and UniCare) to challenge the initiative. This lawsuit was filed despite the efforts of the GIC to keep the MMS informed about our progress and inviting them to participate in the development of the CPI Initiative. As the GIC's Executive Director, Dolores L. Mitchell said in the summer issue of the *For Your Benefit* newsletter, "It is regrettable that the MMS has chosen to be confrontational about the CPI Initiative rather than continuing to work with us to bring quality and efficiency information to patients and providers alike. We would all have benefited had they continued to work with us."

The program continues to evolve and improve. For FY09, the following steps have been taken:

Step 1: health plans increased the number of physician tiers from two to three.

Step 2: health plans were required to tier six core specialties including Cardiology, Endocrinology, Orthopedics, Rheumatology, Gastroenterology and OB/GYN, with the majority of plans tiering other specialties in addition to those six.

Step 3: health plans employed a new approach to tiering, by using "quality of performance" as the initial step ("hurdle") in evaluation, prior to the application of the cost-efficiency measurement.

Step 4: health plans assigned newly practicing physicians (practicing two years or less), other physicians without sufficient data, and/or physicians whose specialty was not being tiered to the same co-pay as the Tier 2 co-pay.

Employers throughout the country and others in the health care field have been eager to learn more about this program and the GIC's Executive Director has been a frequent speaker at local and national health care forums. The GIC will continue to lead the way in improving quality and transparency of health care.

Health Plan and Mental Health Procurements and Management

In an effort to improve administrative efficiencies and meaningfully expand the application of the CPI Initiative, the GIC went out to bid for all of its health plans during Fiscal Year 2008. In the past, the GIC has gone out to bid for its managed care plans (HMOs and PPOs), indemnity, and Medicare plans in different years. Procuring these benefits at once enabled the GIC to put in place greater uniformity in CPI Initiative standards and methodology. This new approach also enabled municipalities who were deliberating about joining the GIC (see page six) to know which health plans the GIC would be offering if they were to join in future years.

Health Plans

Expanded programs and projects were incorporated into our health plan procurement in an effort to fill quality and access gaps in health care treatment, as well as, potentially, to stimulate market change in delivery systems. Even prior to the Commonwealth's announcement (via its Mass Healthy Compact initiative) that state agencies would enforce a policy of non-payment for certain medical errors and preventable events ("never events", such as operating on the wrong part of the body), the GIC required that those bidding on our health plan contracts commit to enforcement of non-payment rules for "never events," as initially outlined by the Centers for Medicare and Medicaid Services (CMS) and subsequently expanded by the National Quality Forum. We also incorporated a requirement for comprehensive wellness programs and a two-year pilot for development of programs modeled after the "medical home" concept, which seeks to improve patient care coordination and management. And we required that, subsequent to the development and licensure in the retail market of "mini (or minute) clinics," our health plans would be expected to contract with such clinics, to broaden access for our members seeking community-based, lower-cost options for health care.

After a rigorous procurement, which elicited interest, but no bids from other carriers, three-year contracts with two one-year renewal options were awarded to all of the GIC's incumbent health plans effective July 1, 2008:

- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- Neighborhood Health Plan
- Tufts Health Plan
- UniCare

The resulting non-Medicare and Medicare rate increases for FY09 represented a 6.42% weighted increase, which compared with a 3.78% increase for FY08 and 7.47% increase for FY07.

Other steps taken:

- To improve members' ability to distinguish one of the GIC's health plan carriers from the GIC itself, the name of the indemnity plans changed to UniCare State Indemnity Plans from the Commonwealth Indemnity Plans.
- Routine eye exam benefits were standardized across all employee health plans and the Medicare Extension (OME) plan: one exam every 24 months as of July 1, 2008.
- A new nationally-available Medicare supplemental plan was introduced for FY09 called Harvard Pilgrim Medicare Enhance, replacing Harvard Pilgrim First Seniority Freedom.

Mental Health Benefits

The contract for mental health and substance abuse benefits for members of all of the indemnity plans and Navigator by Tufts Health Plan was set to expire on June 30, 2008, so the GIC went out to bid for the mental health and substance abuse vendor for FY09 and beyond during FY08. Contract objectives included securing competitive premium rates, identifying a vendor with a commitment to an integrated behavioral health/EAP program and high-quality clinical services, and the assurance of care coordination for members with both medical and behavioral/substance abuse conditions. After a rigorous procurement, it was determined that United Behavioral Health provided the best overall value for GIC members in its financial and technical proposal and that they held superior research, data analytic and clinical focus in their programs. They also offered clinical enhancements to the program that carried significant value to both members and the GIC. Their new three-year contract with two one-year renewal options became effective July 1, 2008.

Audits

In our focus toward ongoing quality improvement, the GIC holds a multi-year contract with Mercer Health & Benefits to conduct audits of our self-insured health plans as well as our pharmacy benefit manager, Express Scripts. Audit activities conducted during this fiscal year were follow-up audits on Harvard Pilgrim Health Care (HPHC) and UniCare. The HPHC audit reflected few issues of concern, while the UniCare audit resulted in recommendations in the areas of claims payment, claims system accuracy and quality of correspondence that required action. As a result of the audit report, UniCare has taken steps toward corrective action and a re-audit has been authorized by the GIC in FY09 to assure complete resolution of issues.

Ongoing Management of Our Programs

GIC Program Managers and other GIC staff communicate daily with all our carriers to keep the programs running smoothly and to iron out problems as they arise. Periodic operations meetings with all of our carriers ensure that programs are running smoothly and efficiently and that service benchmarks are being met. Annual site visits with all of the GIC's health plans allow staff representatives from all operational areas of the GIC an opportunity to address strategic as well as detail-level concerns and questions that are having, or could have, an impact on quality of service to our members.

TEAM FOOTWORK

Helping Municipalities With Soaring Health Care Costs

On July 25, 2007, Governor Deval Patrick signed into law Chapter 67 of the Acts of 2007 which allows municipalities the option of joining the Group Insurance Commission's health coverage. The law enables municipalities to reduce health insurance costs for their employees and retirees by joining the GIC's state enrollee pool. It requires municipal unions and management officials to employ coalition bargaining to negotiate the conditions for entering the GIC. A vote of 70% of the municipality's Public Employee Committee is required to join. Pursuant to the law, a member of the Massachusetts Teachers Association and a municipal administrator plus two new public members were added to the Commission.

Step One: Getting the Word Out

Who is the GIC? What are the GIC's benefits? How does the new law work? Why should we consider this option? Municipalities had many questions about the new option and the GIC developed multiple communications to help them with their analysis:

- Participation in many regional and local presentations and listening tours sponsored by the Lieutenant Governor, major legislative sponsors of the bill, and trade groups;
- Teleconference and in-person presentations by the GIC to local communities;
- Comprehensive question and answer document about the law and its provisions;
- Informational CDs that included multiple comprehensive documents about the GIC and its benefits; and
- New sections of the GIC's website, which were enhanced throughout the year.

Step Two: Implementing Town of Saugus

The Town of Saugus came into the GIC on January 1, 2008. With little lead time, Saugus and GIC staff threw themselves into ensuring a smooth transition:

- New communication materials, enrollment forms, and required documentation information were developed and mailed;
- A new systems infrastructure was developed, which incorporated necessary new billing reports;
- A nine-hour registration was held on a Saturday to answer questions and enroll employees and retirees; and
- Over 870 Saugus enrollees were successfully enrolled into the GIC with health plan identification cards received before the January 1, 2008 start date.

These efforts paid off and the town projected that they saved over a half million dollars in the first eight months of the program.

Step Three: Implementing New Municipalities and Other Entities for July 1, 2008 Coverage

Cities, towns and other entities now eligible for GIC health insurance must provide the GIC notice to come in by October 1 of any year for the following July 1 coverage effective date. This gives the towns and the GIC time to complete all of the necessary tasks:

- Notifying retirees of towns without mandatory Medicare that they must enroll during Medicare's January through March open enrollment period
- Collection of required documentation (including birth certificates, divorce decrees, and Medicare documentation)
- Data loads to the system, which frequently includes multiple iterations before they are accurately transmitted to the GIC.

All of these tasks must take place before the GIC's spring open enrollment begins.

The GIC worked with the following municipalities, regional school districts and planning councils to ensure a smooth transition for July 1, 2008:

- Athol-Roylston School District
- Groveland
- Gill-Montague Regional School District
- Hawlemont Regional School District
- Holbrook
- Millis
- Mohawk Trail Regional School District
- Old Colony Planning Council
- Southeastern Regional Planning and Economic Development District

The GIC's regular annual enrollment health fairs were scheduled in locations close to these new municipal groups. Additional Saturday fairs and hours of certain other health fairs were extended to ensure that teachers from these districts could attend, and the GIC's information technology department developed a new database to expedite the enrollment process at the fairs. Customized forms, procedural manuals, benefits charts and an all-new *Benefit Decision Guide* for municipalities were developed, produced and distributed. The bottom line – nearly 3,000 new municipal contracts came into the GIC for coverage July 1, 2008, and the new municipalities report being pleased with the savings and service they received through the GIC.

Communications, Implementing and Improving Programs

Health Care Reform Act

The GIC continued to collaborate with Administration and Finance, the Health Connector Authority, and the Comptroller to implement the final requirements for the ground-breaking Health Care Reform Act. New Internal Revenue Code Section 125 documents, which formalize the purchase of health benefits on a pre-tax basis, were written for GIC-eligible and non-GIC eligible employees.

Under the new law, a Health Insurance Responsibility Disclosure (HIRD) form must be distributed to all employees who do not elect GIC coverage. A customized HIRD form was developed for agencies using the HR/CMS payroll system, while the standard HIRD form was disseminated to offline agencies. Procedural information was developed and trainings were held for coordinators located at agencies across the state so that they were familiar with their responsibilities for distributing and collecting the HIRD forms for employees who do not elect GIC coverage.

The GIC got the word out to agencies about the special open enrollment for non-GIC eligible state employees to purchase health coverage on a pre-tax basis through the Connector Authority. In addition to serving as the conduit for disseminating this information, the GIC established a section of our website to help communicate this option on an ongoing basis.

The GIC continued to work to refine the dependent age 19 and over expanded coverage option, facilitating imputed income requirements for Non-IRS dependents and fine tuning the Dependent Age 19 and Over Application for Coverage form so that it was easier to use.

With all state residents required to have health coverage by January 1, 2008, the GIC worked with our health plans to ensure that new 1099-HC forms, which provides proof of health coverage, were distributed for state income tax purposes before the end of January.

Voluntary Data Sharing

The GIC continued to work to improve the transfer of data between the GIC and the Centers for Medicare and Medicaid Services (CMS). During FY08, this voluntary data sharing was fully automated, helping to ensure that the GIC is charged first when we, not Medicare, are the primary insurer for active employees ages 65 or over. When health care providers bill Medicare and not the GIC health plan for an active employee age 65 or over, the Commonwealth can be charged interest on the Medicare claims. This new automated system helps to eliminate expensive billing issues.

Medicare Part D

The GIC continued to participate in the federal subsidy program for employers that offer prescription drug benefits for their Medicare retirees. This program requires data sharing between the GIC, the Centers for Medicare and Medicaid Services (CMS), two of our Medicare HMO health plans, and the pharmacy benefit manager for the Medicare indemnity plan. In FY08 CMS sent over $21.3 million in payments to the Commonwealth's General Fund as the result of these efforts.

Other Post Employment Benefits (OPEB)

Retiree health care and basic life insurance costs for those retirees whose benefit costs are the Commonwealth's liability under the Government Accounting Standards Board rules were separated from all other GIC health care and basic life insurance costs so that the liability for those retirees' benefits could be separately identified. Changes to the law created new payment streams and during FY08 staff worked with Administration and Finance, the Comptroller and Treasurer to satisfy these new reporting and payment requirements.

Communications

Providing employees with a clear and concise understanding of the Clinical Performance Improvement Initiative and how their choice of providers affects their benefit levels was a complex challenge. To address this challenge, the GIC employed multiple strategies to get the word out, which resulted in minimal employee questions and concerns about the new three tiers during annual enrollment.

- Standardized tiering descriptions: Previously, each health plan had used their own labeling of the health plan tiers. With the migration to three tiers, standardized names and descriptions were critical for improving member understanding of the program. To address this need, the GIC developed standardized descriptions incorporated into all health plan provider directories and marketing materials:

  ★★★Tier 1 (excellent)
  ★★Tier 2 (good)
  ★Tier 3 (standard)

- *Benefit Decision Guide*: This booklet informs enrollees of their upcoming benefit choices and provides detailed information to help facilitate their selection process. Each guide provided "sample scenarios" of how individuals in various circumstances could maximize their health plan benefits.
- *For Your Benefit* newsletter: Every issue of the newsletter included updates and information on the GIC's CPI Initiative.
- Annual enrollment letter: Mailed to enrollee homes, this letter provided enrollees with valuable information about the upcoming enrollment and the new third tier.
- Website: All content from the GIC's *Benefit Decision Guide* and other materials was incorporated into the GIC's website with links to all health plans, allowing enrollees to find tiers of individual physicians.
- Emails: Information was sent to state employees on the state's central email list and, for those employees not on this list, emails were sent to Coordinators to be forwarded to their employees.
- Health fairs: A PowerPoint presentation was shown at a table at all of the GIC's annual enrollment health fairs, which described 2008 benefit plan changes and the CPI Initiative.
- Coordinator training sessions: The GIC conducted five training sessions across the state for benefits office personnel. Held prior to annual enrollment, these sessions informed Coordinators about the reasons for and the changes to the CPI Initiative. The sessions included a health plan panel to which attendees could direct their questions.

Collaboration

Improving health care quality and cost-efficiency cannot be accomplished in a vacuum and the GIC was actively involved on multiple fronts to collaborate with others. In part as a result of the GIC's innovative CPI Initiative, the GIC's Executive Director, Dolores Mitchell, was asked to serve on a number of national health policy boards including the National Committee for Quality Assurance (NCQA), the National Hospital Quality Alliance, and the Electronic Health Initiative (eHI). She is also a member of the governing board of the Mass Health Connector Authority, and the Quality and Cost Council.

In FY08, the announcement of the Mass Healthy Compact Initiative was an exciting development and representation from the GIC on almost all of its related task forces and committees was a necessity. Additionally, independently-formed groups such as the Partnership for Healthcare Excellence, which seeks to improve patient education, consumer-advocacy and action in health care arena for Massachusetts residents, requested GIC representation on their Leadership Council, and we have been pleased to participate. Our collaborative efforts with state as well as national organizations and groups committed to the improvement of health care quality, patient safety and provider performance continued at a stepped-up pace, with a greater sense of urgency in the national debate. New groups that the GIC has participated with include the Massachusetts Prescription Reform Coalition and the State Quality Improvement Institute. As in years past, we remained active in the Massachusetts Coalition for the Prevention of Medical Errors, the Massachusetts Health Data Consortium, Associated Industries of Massachusetts (A.I.M.) Health Care Committee, the Massachusetts Compassionate Care Coalition, and the New England Employee Benefits Council.

Steps To Climb

The GIC will continue to improve its Clinical Performance Improvement Initiative, engaging members, health plans and providers to improve quality and rein in unsustainable cost increases. In addition to these goals, pressing challenges loom on the horizon.

The ramifications of the current economic tailspin will reverberate throughout state government. With an expected shortfall in state revenues and substantial budget cuts in FY09, and the outlook for FY10 bleak, the GIC will do its part to share the burden of these shortfalls while trying to mitigate the effect on members to the largest degree possible.

These same economic pressures are being felt at the local level, which will result in more municipalities taking a closer look at the GIC option. With limited staff and systems resources, adding multiple municipalities will be a challenge. The GIC, however, will continue to support this important initiative that benefits municipalities and their employees, retirees, and residents.

The GIC looks forward to continuing its steps to improve health care quality while containing costs. All of us have a role in these efforts – the GIC, our members, physicians, hospitals, and health plans - and the GIC will continue to collaborate with others to achieve these objectives for the benefit of our members and the taxpayers of the Commonwealth.

GROUP INSURANCE COMMISSION
STATEMENT OF EXPENDITURES
JULY 1, 2007 - JUNE 30, 2008

DESCRIPTION	COMMONWEALTH	EMPLOYEES
Administration (a)	$3,053,583	$0
State Employees and Retirees' Basic Life Insurance	$9,322,855	$1,779,864
State Employees' Optional Life Insurance	$0	$22,175,377
State Employees' Health Insurance (b)	$1,105,878,988	$224,043,341
State Employees' Dental And Vision for Managers, Legislators, Legislative Staff and Certain Employees of the Executive Offices	$6,943,761	$1,354,913
Long Term Disability For State Employees	$0	$11,495,168
Elderly Governmental Retirees' Health Insurance (c)	$669,669	$105,653
Retired Municipal Teachers' Life Insurance	$958,463	$207,652
Retired Municipal Teachers' Health Insurance	$80,022,234	$14,136,557
Retirees' Dental Insurance	$0	$4,100,022
Grand Totals	$1,206,849,553	$279,398,547

(a) Plus an additional $686,133 from employees' trust funds which were used to pay administrative costs such as postage, telephone and supplies. These amounts are included on the next two statements.

(b) Medical and prescription drug co-payments and deductibles for FY08 totaled approximately $110,125,318.

(c) The EGR share includes $29,028 from the EGR Trust Fund and $19,544 from the EGR Rate Stabilization Reserve. These amounts are subsidies to these retirees' premiums.

RATE STABILIZATION RESERVE STATEMENT
JULY 1, 2007 - JUNE 30, 2008

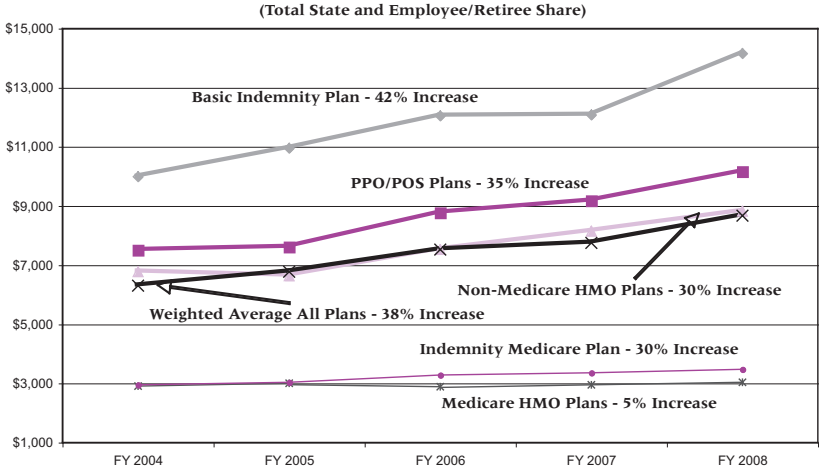
RESERVE	BALANCE 7/1/07	RECEIPTS 7/01/07-6/30/08	EXPENDITURES 7/01/07-6/30/08	BALANCE 6/30/08
Basic Life	$4,390,620.63	$196,834.77	$0	$4,587,455.40
Optional Life	$27,323,057.17	$1,098,864.65	$3,000,000.00	$25,421,921.82
Employee Health	$69,533.28	$3,069.32	$0	$72,602.60
Elderly Governmental Retiree Health	$210,029.68	$8,273.02	$19,544.48	$198,758.22
Retired Municipal Teacher Life	$102,229.46	$4,583.30	$0	$106,812.76
Retired Municipal Teacher Health	$27,442.14	$1,230.30	$0	$28,672.44
TOTAL	$32,122,912.36	$1,312,855.36	$3,019,544.48	$30,416,223.24

Financial and Trend Reports

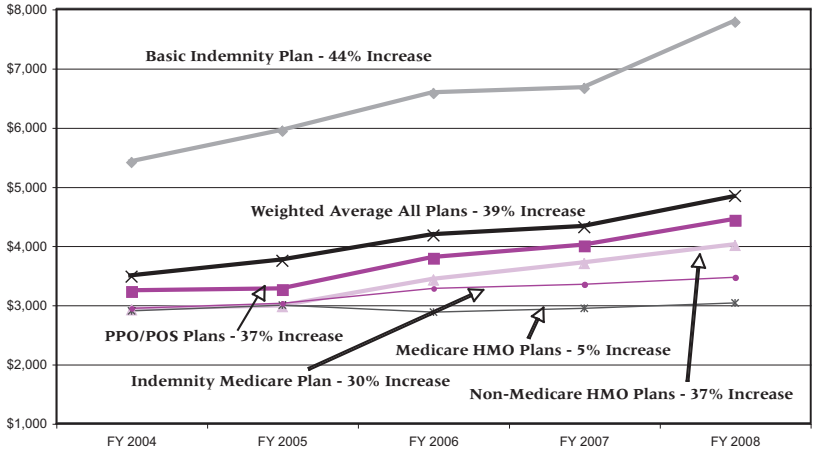
EMPLOYEES' TRUST FUND STATEMENTS
JULY 1, 2007 - JUNE 30, 2008

	State Employees' Trust Fund	Elderly Governmental Retirees' Trust Fund	Retired Municipal Teachers' Trust Fund
Balance 7/1/07	$2,948,696.43	$221,722.37	$0.19
Receipts	$2,468,838.45	$8,557.16	$0
Expenditures	(-$686,133.16)	(-$29,027.97)	$0
Balance 6/30/08	$4,731,401.72	$201,251.56	$0.19

COST PER SUBSCRIBER (ENROLLEE)*
(Total State and Employee/Retiree Share)



COST PER CAPITA*
(Total State and Employee/Retiree)



*Through FY04, PPO/POS Plans included The Commonwealth PPO and Indemnity PLUS. Beginning in FY05, the PPO/POS Plans included Indemnity PLUS, Indemnity Community Choice, HPHC POS/PPO, and Navigator by Tufts Health Plan. The HPHC and THP non-Medicare HMO plans were discontinued in FY04.

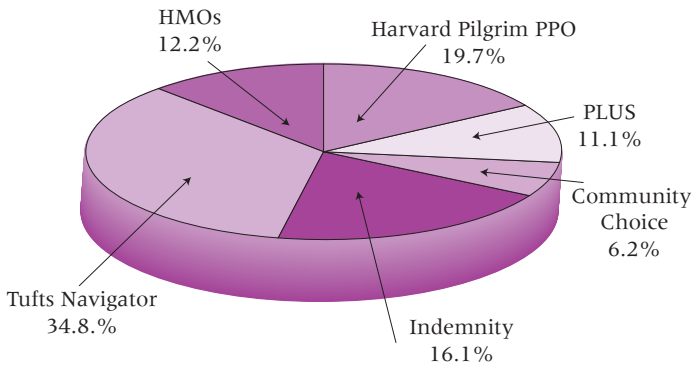
HEALTH PLAN MEMBERSHIP BY INSURED STATUS FY2008

	TOTAL ACTIVE*	TOTAL RET & SUR	TOTAL EGR&RMT	TOTAL ENROLLEES	TOTAL DEPENDENTS	TOTAL LIVES
UniCare Indemnity Plan	13,612	54,797	11,339	79,748	21,550	101,298
UniCare PLUS	9,344	1,647	0	10,991	13,323	24,314
UniCare Community Choice	5,202	644	0	5,846	6,547	12,393
Fallon Community Health Plan Direct	994	106	16	1,116	1,108	2,224
Fallon Community Health Plan Select	2,298	1,106	123	3,527	3,587	7,114
Harvard Pilgrim Health Care	16,657	2,721	19	19,397	25,137	44,534
Health New England	5,988	1,562	194	7,744	8,301	16,045
Neighborhood Health Plan	1,004	36	70	1,110	1,071	2,181
Tufts Health Plan	29,365	6,117	174	35,656	43,516	79,172
Total UniCare Indemnity Plan	13,612	54,797	11,339	79,748	21,550	101,298
Total PPO-Type Plans	60,566	8,084	0	66,650	88,523	157,173
Total HMOs	10,286	5,855	596	16,737	14,067	30,804
TOTAL-ALL	84,464	68,736	11,935	165,135	124,140	289,275
Indemnity Plan % Total	16%	80%	95%	48%	17%	35%
PPO-Type % Total	72%	12%	0%	42%	71%	54%
HMO % Total	12%	9%	5%	10%	11%	11%

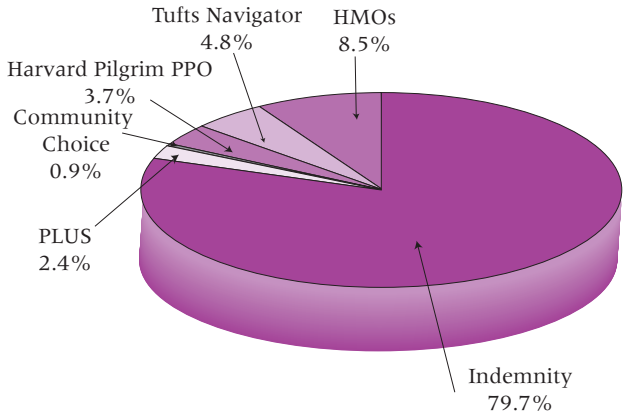
*Active enrollment includes enrollment figures for enrollees with IRS or non-IRS dependent coverage.
Source: Pool I Age/Sex Composition Analysis, Fiscal Year 2008 and Pool II Age/Sex Composition Analysis, Fiscal Year 2008.

FY 2008 ENROLLMENT

Active Employees by Plan Type - FY 2008



Retirees and Survivors by Plan Type - FY 2008



Source: Pool I Age/Sex Composition Analysis, Fiscal Year 2008
Does not include EGRs and RMTs.

COMMONWEALTH OF MASSACHUSETTS

DEVAL PATRICK, Governor

TIMOTHY P. MURRAY, Lieutenant Governor

GROUP INSURANCE COMMISSION

DOLORES L. MITCHELL, Executive Director

COMMISSIONERS

THOMAS A. SHIELDS, Chair

RICHARD E. WARING (NAGE), Vice Chair

SUZANNE BAILEY, *Designee for Nonnie S. Burnes, Commissioner of Insurance*

HARRIS A. BERMAN, M.D.

MARY ANN BRADLEY, *Designee for Leslie A. Kirwan, Secretary of Administration and Finance*

THERON R. BRADLEY

STEPHEN B. CHANDLER (Local 5000, SEIU, NAGE)

DAVID M. CUTLER (Health Economist)

DAVID R. HANDY

KAREN HATHAWAY (Council 93, AFSCME, AFL-CIO)

RICHARD J. KELLIHER *(Massachusetts Municipal Association)*

MARK P. KRITZMAN

ANNE M. PAULSEN *(Retiree Member)*

PAUL F. TONER *(Massachusetts Teachers Association)*

COMMONWEALTH OF MASSACHUSETTS
GROUP INSURANCE COMMISSION
PO Box 8747, Boston, MA 02114-8747
617.727.2310
TDD/TTY 617.227.8583
www.mass.gov/gic

RED SUN PRESS